UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Vpriv (velaglucerase)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA

- **DOCUMENTED** diagnosis of **Gaucher's Disease**
- Copy of prescription from physician
- Medicaid must be notified of changes in dosage with a copy of a new prescription.

NOTE:

Please bill with J-code J3385 and an appropriate NDC.

AUTHORIZATION:

6 months.

RE-AUTHORIZATION:

1 year with documentation of significant improvement

02/06/2014

http://health.utah.gov/medicaid/pharmacy